KISD Benefit Change Form 2016-2017

Employee Name:	
Date of Change:	

Employee ID#	
Effective Date :	

FORM WILL NOT BE ACCEPTED AFTER THE 30th DAY OF THE QUALIFING EVENT

Reason for Change: (Choose One)

- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce
- ☐ Death
- ☐ Involuntary Loss of Coverage
- ☐ Employment Status Change
- ☐ ON LEAVE FROM DISTRICT

Documentation: (Choose One)

- ☐ Birth/Death Certificate
- ☐ Marriage License
- ☐ Proof of Other Coverage
- ☐ Divorce Decree
- ☐ Other _______________

PLEASE COMPLETE THE SECTION BELOW ONLY FOR DEPENDENTS YOU WANT TO ADD OR DROP UNDER EACH PLAN.
WRITE *ADD* OR *DROP* IN THE APPROPRIATE SPACE BELOW.

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Medical	Dental	Vision	Dependent Life	Cancer	Gender
Spouse								M F
Dependent								M F
Dependent								M F
Dependent								M F
Dependent								M F

Special Instructions:

All Amounts Shown Are Monthly Premiums
Clearly indicate your Selections

Medical Coverage

	ActiveCare 1HD	ActiveCare Select	ActiveCare 2
Employee Only	$ 30.00	$ 143.00	$ 277.00
Employee + Child(ren)	$ 231.00	$ 381.00	$ 634.00
Employee + Spouse	$ 388.00	$ 628.00	$ 1,003.00
Employee + Family	$ 633.00	$ 790.00	$ 1,058.00

Waive ___________ No Change______________

Regular Leave of Absence RATES

(Includes District Portion)

	Active Care 1HD	Care Select	Active Care 2
Employee Only	$ 341.00	$ 484.00	$ 645.00
Employee + Child(ren)	$ 615.00	$ 779.00	$ 1,042.00
Employee + Spouse	$ 914.00	$ 1,147.00	$ 1,552.00
Employee + Family	$ 1,231.00	$ 1,361.00	$ 1,597.00

Waive ___________ No Change __________

Dental Coverage

	PPO	DHMO
Employee Only	$30.16	$11.38
Employee + Child(ren)	$73.52	$23.72
Employee + Spouse	$59.20	$20.20
Employee + Family	$102.14	$34.68

Waive ___________ No Change ___________

Vision Coverage

	Vision
Employee Only	$ 6.32
Employee + Child(ren)	$ 10.14
Employee + Spouse	$ 9.04
Employee + Family	$ 17.18

Waive ___________ No Change___________

Flexible Spending

				Annual Limits		
Medical-Health Care	$	Per Month	(25.00 Per Month Minimum)	Min $300	Max $2,250	$2,550.00 Annually if medical coverage with Klein ISD is waived. Contact the Benefits Office for Details
Dependent DayCare	$	Per Month		Min $300	Max $5,000	

Waive ___________ No Change ___________

* **Newly elected coverage will begin the first day of the following month after the date of lost coverage.**
Dropped coverage will begin at the end of the month following receipt of this form in the Benefits Office.

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Supplemental Term Life

Employee Age	Spouse Age	Rate
<30	<30	0.047
30 - 34	30 - 34	0.057
35 - 39	35 - 39	0.066
40 - 44	40 - 44	0.085
45 - 49	45 - 49	0.123
50 - 54	50 - 54	0.179
55 - 59	55 - 59	0.255
60 - 64	60 - 64	0.312
65 - 69	65 - 69	0.444
70 - 74	70 - 74	0.916
75>	75>	1.888
Child(ren) Life	Rate per Mo.	
$5,000	$0.88	
$10,000	$1.75	

Coverage: Increments of $10,000 up to 5X salary or $500,000 maximum

Employee and Spouse rates are per $1,000 of coverage per month

Example: A 37 year old elects $150,000 coverage amount				
150	X	0.066	=	$9.90 per month
(per 1,000 coverage)	X	(conversion rate)		Monthly premium

I elect: Employee Term Life Coverage ____________________

Waive Employee Term Supplemental Life _______________

NO CHANGE______________

*** I elect: Spouse Term Life Coverage** ____________________

Waive Spouse Term Supplemental Life _______________

NO CHANGE______________

*** I elect: Child(ren) Term Life Coverage** ____________________

Waive Child Term Supplemental Life _______________

Child(ren) Term Life is Flat rate per month for all children

NO CHANGE______________

**** Spouse and Child(ren) coverage can not exceed the employee coverage***

**** Changes to Life Coverage may require Medical Underwriting***

Whole Life Insurance

*Information available from the HUB or the Benefits Office

Requested Coverage Amount	Cost
$________	$ ________

Waive Whole Life ___________ NO Change ____________

Life Insurance Beneficiary Designation

I hereby request that any payment payable to a beneficiary(ies) after my death in accordance with the life insurance contract and/or the covered plan shall be paid to the beneficiary(ies) listed below. All previous beneficiary designations are cancelled. This designation includes, and is subject to, the Provisions set by the Life Insurance provider contracted with KISD. This beneficiary designation will be effective for any KISD provided or voluntary Life Insurance plan provided through KISD.

First Name	Last Name	Relationship	% To Pay	Primary or Contingent

Disability Insurance

*See your Benefits Booklet to complete your selection below

Elimination Period	Monthly Benefit	Cost
______ days	$________	$ ________

A waiver of elimination period if you are confined in a hospital only apply to the 14/14 or 30/30 elections.

Waive Disability _______ No Change ________

Critical Illness

	Option 1	Option 2
Premiums are age banded and available for all eligible family members	10,000 Benefit	20,000 Benefit
Contact the Benefits Office		

Waive Critical Illness Plan ______ No Change ________

Group Legal Plan

	Rate
Legal Service Only	$ 15.76
Legal Service & Identity Theft	$ 25.70

Waive Group Legal ________ No Change ________

I hereby authorize the above changes and amounts to be deducted from my pay.

Signature:___________________________________ **Date:**____________________

Documentation Received By:		**Please return completed forms and documentation to the Benefits Office**

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